TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Universal DME LLC

Respondent Name
Ace American Insurance Co

MFDR Tracking Number
M4-16-1151-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
January 4, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We should be paid for services rendered because we have submitted the appropriate paperwork for review."

Amount in Dispute: $71.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "DWC Rule 134.600(p)(12) applies to this item as its use falls outside of the ODGs, and preauthorization was required. Because preauthorization was not obtained, payment for the items is not owed."

Response Submitted by: Downs ♦ Stanford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 11, 2015	L3908	$71.98	$65.59

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Payment adjusted for absence of precert/preauth

- ODG – Services exceed ODG guidelines; preauth is required
- W3 – Appeal/Reconsideration
- Per ODG: Recommend for displaced fractures. Immobilization is standard for fracture healing although patient satisfaction is higher with splinting rather than casting. No wrist/hand fracture has occurred.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 197 – "Payment adjusted for absence of precert/preauth" 28 Texas Administrative Code §134.600 (p)(12) requires that

   Non-emergency health care requiring preauthorization includes:

   > Treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits);

   The service in dispute is L3908 with a description of "Wrist hand orthosis, wrist extension control cock-up, non molded, prefabricated, off the shelf."

   The carrier states in their position statement, "Per the ODGs, this items is recommended for a displaced fracture;" Review of the ODG Guidelines finds for "Splints," "Recommended for treating displaced fractures." The product delivered is not classified as a splint but rather an orthotic. The Division finds the insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. 28 Administrative Code 134.203 (d) states,

   > The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:
   >
   > (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;

   Review of the 2015 Texas DMEPOS fee schedule found at www.cgsmedicare.com finds an allowable of $52.47. The calculation of the maximum allowable reimbursement is calculated as follows: $52.47 x 125% = $65.59.

3. The total allowable for the service in dispute is $65.59. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $65.59.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $65.59 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		January , 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.